

OEO Form 101

EMERGENCY SHELTER GRANTS PROGRAM

SECTION I - IDENTIFICATION

LEGAL NAME OF APPLICANT ORGANIZATION:

MAILING ADDRESS: _____

COUNTY IN WHICH FACILITY IS LOCATED: _____ Fed I.D. #: _____

EXECUTIVE DIRECTOR OF APPLICANT ORGANIZATION: _____

(The executive director will receive all correspondence regarding this grant.)

TELEPHONE NUMBER: _____ FAX: _____ Email: _____

NAME OF FACILITY OPERATED (if different from above):

NAME OF FACILITY DIRECTOR (if different from above): _____

STREET ADDRESS (if different from that of applicant organization):

Is the address of the facility confidential? ____YES ____NO

SECTION II - CERTIFICATION:

This application for Emergency Shelter Grants
Program funds has been reviewed and approved
by the applicant governing board or by a duly
appointed board committee.

Typed Name of Governing Board Chairperson

Signature*

Date Approved (Month/Day/Year)

*If signed by anyone other than board chairperson, please attach a resolution of the applicant organization's board authorizing the signatory.

SECTION III - ASSURANCES & CERTIFICATIONS

I, _____, Chairperson of the
Governing Board, of _____

(Name of Applicant Organization)

acknowledge that funds available under the FY 2006 Emergency Shelter Grants Program will be used to serve individuals and families who meet the definition of "homeless" used in the McKinney-Vento Homeless Assistance Programs. These funds will be used for Operations only or Essential Services and Operations, or Homeless Prevention and Operations, or Essential Services/Homeless Prevention and Operations; and certify that:

1. In connection with the option selected, funds will be utilized to:

A. Provide services concerned with employment, health, drug abuse, and education, and may include:

1. assistance in obtaining permanent housing
2. medical and psychological counseling and supervision
3. employment and nutrition counseling
4. substance abuse treatment and counseling
5. assistance in obtaining Federal, State and local assistance, including mental health benefits, employment counseling, medical assistance, Veteran's benefits, and income support assistance such as Supplemental Security Income benefits, General Assistance, Temporary Assistance for Needy Families (TANF) and Food Stamps
6. other services such as child care, transportation, job placement and job training
7. staff salaries necessary to provide the above services

Essential services may be provided only if the service is a new service, or is a quantifiable increase in the level of a service above that which was provided with local funds during the 12 calendar months immediately preceding receipt of Emergency Shelter Grants Program funds; and not more than **30 percent** of the total grant amount may be used for these services.

B. Provide payment of costs associated with the operation of a facility providing shelter and services to homeless individuals and families including staff costs (**administrative staff costs cannot exceed 10% of total grant amount;**) rent; utilities; food and furnishings, minor and/or routine building maintenance and repair; equipment; property insurance;

C. If homeless prevention funds are sought, develop and implement homeless prevention activities as described below:

1. Short-term subsidies to defray rent and utility arrearages for families that have received eviction or utility termination notices;
2. Security deposits of first month's rent to permit a homeless family to move into its own home;
3. Mediation services for landlord/tenant disputes;
4. Legal services for the representation of indigent persons in eviction proceedings;
5. Payments to prevent the incidence of homelessness.

If grant funds are to be used to assist families that have received eviction notice or notices of termination of utility services, the following conditions *must* be met:

1. The inability of the families to make the required payments must be the result of a sudden reduction in income.
2. The assistance must be necessary to avoid eviction of the family or termination of services to the family.
3. There must be reasonable prospect that the family will be able to resume payments within a reasonable period of time.
4. The assistance must not supplant funding for preexisting homeless prevention activities from any other source.

Clients receiving homeless prevention assistance will be provided or referred to services that may preclude their continued dependence on emergency assistance. These services could include individual or group budgeting, employment and/or educational counseling.

Not more than 30% of the total grant amount may be expended on Homeless Prevention.

2. Fiscal controls and accounting procedures necessary to assure proper dispersal of and accounting of Emergency Shelter Grants Program funds have been established in accordance with OMB Circulars A-110 and A-122 for non-profits. In addition, where combined state funds are received, used or expended of at least \$15,000, but less than \$300,000 annually, a sworn accounting of receipts and expenditures of the state funds and an Activities and Accomplishments Report must be filed with the State Auditor and the North Carolina Department of Health and Human Services within six months after the end of the agency's fiscal year.
3. All program clients and fiscal records will be retained for a period not less than four years following completion of the contract or until all audits are resolved.

4. Any building for which Emergency Shelter Grants Program funds are used for eligible activities described in 576.21(a)(2), (a)(3), and (a)(4) must be maintained as a shelter for the homeless for the period during which such assistance is provided. A substitute site or shelter may be used during this period, so long as the same general population is served. The Office of Economic Opportunity will be informed immediately if there is a change during the contract period in the operation, location and/or service population of any homeless facility funded with Emergency Shelter Grants Program funds.
5. To the maximum extent practicable, homeless individuals and families will be involved in maintaining and operating the facility and in providing services for occupants of the facility.
6. The shelter will not use debarred, suspended or ineligible contractors in accordance with the requirements of 24 CFR Part 24.
7. The shelter will maintain a drug free workplace in accordance with the requirements of 24 CFR Part 24, Subpart F.
8. No person shall, on the grounds of race, color, national origin, or sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available under the Emergency Shelter Grants Program. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with respect to an otherwise qualified handicapped individual as provided in Section 504 of the Rehabilitation Act of 1973, 24 CFR Part 100 of the Fair Housing Act, the Housing and Urban Development Act of 1978-Section 3, and Executive orders 11063, 11246, 11625, 12432, and 12138 shall also apply. Procedures will be instituted to ensure that this policy and available services and facilities are made known to all.
9. Facilities receiving Emergency Shelter Grants Program funding are subject to the requirements, as applicable, of the Lead-Based Paint Poisoning Prevention Act (LBPPPA) and the Act's implementing regulations at 24 CFR Part 35.

TYPED NAME OF GOVERNING BOARD CHAIRPERSON

SIGNATURE*

DATE

*If signed by anyone other than board chairperson, please attach a resolution of the applicant organization's board authorizing the signatory.

ASSURANCES REGARDING THE CONDUCT AND/OR PROVISION OF RELIGIOUS SERVICES AND INSTRUCTION
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I, _____, Chairperson of the Governing Board of

(Name of Applicant Organization)

which ____ is ____ is not a primarily religious organization, certify that:

1. All eligible activities under the Emergency Shelter Grants Program conducted by

_____ during the FY 2006 ESG grant
(Name of Applicant Organization)

period will be provided in a manner that is free from religious influence and in accordance with the following principles, the organization named above:

- a. Will not discriminate against a person currently receiving its shelter and/or services or any person applying for shelter or any of the eligible activities under the Emergency Shelter Grants Program on the basis of religion and will not limit such housing or other eligible activities or give preference to persons on the basis of religion; and
 - b. Will not engage in inherently religious activities, such as worship, religious instruction or proselytizing as part of the programs or services funded, in whole or part, with Emergency Shelter Grants (ESG) Program funding. If an organization conducts such activities, the activities must be offered separately, in time and location, from the programs or services funded with ESG funding.
 - c. Will not require clients to attend religious services and/or receive any religious instruction as a condition of their receiving shelter and/or services provided by the organization.
2. A client or resident who declines to attend religious services or receive religious instruction offered in the facility will suffer no reprisals including withdrawal of privileges, termination of residence in the facility or withdrawal of essential services heretofore provided.

TYPED NAME OF GOVERNING BOARD CHAIRPERSON

SIGNATURE*

DATE

* If signed by anyone other than board chairperson, please attach a resolution of the applicant organization's board authorizing the signatory.

TERMINATION OF ASSISTANCE CERTIFICATION

Section 1402(d) of the Housing and Community Development Act (HCDA) of 1992 amends Section 415 of the Stewart B. McKinney Homeless Assistance Act and states:

"If an individual or family who receives assistance . . . from a recipient violates program requirements, the recipient may terminate assistance in accordance with a formal process established by the recipient that recognizes the rights of individuals affected, which may include a hearing."

ATTACH COPY OF APPLICANT ORGANIZATION TERMINATION OF ASSISTANCE POLICY BEHIND THIS PAGE. This policy should be approved by the organization's governing body and must clearly outline the procedure available to program clients/residents to file grievances regarding program services or appeal their suspension or termination from program services including facility residency. An acceptable termination of assistance policy must include

- 1) the name of the person/persons with whom the grievance or appeal should be filed,
- 2) the person/persons who will review the grievance or appeal,
- 3) the method of review to be used, i.e. formal hearing, staff/client interviews, etc.,
- 4) the time requirements on the client for filing the grievance or appeal; and,
- 5) the time requirements on the organization for review of the grievance or appeal and rendering of a final decision.

Clients should be allowed to file grievances and/or appeals orally if needed. Staff making decisions to suspend or terminate services to the client or who are the subjects of a client grievance may not have the authority to decide the validity of a client grievance or appeal or be involved in the final disposition of the grievance or appeal.

I, _____, Chairperson of the

Governing Board of _____
certify that a termination of assistance policy has been established by the governing board in accordance with the requirements of Section 1402(d) of the Housing and Community Development Act (HCDA) of 1992 that amends Section 415 of the Stewart B. McKinney-Vento Homeless Assistance Act, as evidenced by the termination of assistance policy that is attached.

TYPED NAME OF GOVERNING BOARD CHAIRPERSON*

SIGNATURE

DATE

* If signed by anyone other than board chairperson, please attach a resolution of the applicant organization's board authorizing the signatory.

STATISTICAL REPORTING REQUIREMENTS

In order to satisfactorily complete a mid-year and end-of-year Performance Report, all FY 2006 ESG Grantees must collect the following statistical information on the persons served and services provided during the grant period. Mid-year reports will cover the period of 7/1/2006– 12/31/2006. End-of-year reports will cover the period of 7/1/2006 – 6/30/2007.

- * Average daily occupancy of shelter/facility during the grant period.
- * Number of **unduplicated** persons served by your agency during the grant period reported by total number and in the following categories:
 - Number of Single Individuals NOT in families
 - Adults: Ages 18 +
 - Children: Ages 0 - 17
 - Number of Persons in Families
 - Adults: Ages 18 +
 - Children: Ages 0 - 17
- * Number of Families Served during the grant period
- * Primary Reason for Homelessness Experienced by Persons Served (Report **number** of persons served in each category listed below):
 - Mental Illness
 - Chronic alcoholism
 - Chronic drug abuse
 - Dual Diagnosis (both severe mental illness and chronic alcohol or other drug abuse)
 - Domestic Violence/Sexual Assault
 - Eviction
 - HIV/AIDS
 - Unemployment
 - Underemployment
 - Natural Disaster
 - Homeless and/or Runaway Youth (17 years and below)
 - Child Abuse and Neglect
 - Juvenile Delinquency
 - Release from Prison
 - Transient/Relocation
 - Health Related Disability
 - Other
- * Number of Unaccompanied **Single Female Individuals** and **Single Male Individuals** served in following age groups:
 - 17 & under
 - 18 - 30
 - 31 – 54
 - 55 & over
- * Number of **Male Adults** and **Female Adults** in Families Served in following age groups:
 - 18 - 30
 - 31 - 54
 - 55 and over

- * Number of **Male Children** and **Female Children** in Families Served in following age groups:
 - under 1
 - 1 - 5
 - 6 - 12
 - 13 – 17

- * Veteran Status of **Male** and **Female** Persons Served

- * Number of Persons Served in Racial/Ethnic Categories Below:

Asian
Native Hawaiian/Other Pacific Islander
Black/African-American
Native American/Alaskan Native
White
White/African-American
American Indian/Alaskan Native & White
American Indian/Alaskan Native & Black
Asian/White
Asian/Black
Native Hawaiian/Other Pacific Islander/Asian
Other Multi-Racial
Unknown
Hispanic

- * Amount of Increase in the Number of Persons Served in each applicable category below as a result of ESGP funding
 - Employment Services
 - Substance Abuse Services
 - Housing Referral Services
 - Other
 - Health Services
 - Education Services
 - Nutritional Counseling
- * Number of Persons who received Homeless Prevention Services and the Types of Services Provided.

I, _____, Chairperson of the
governing board of _____, certify
that the statistical information noted above will be collected for reporting in the Mid-Year and
Annual Performance Reports required by the Office of Economic Opportunity during and
immediately following the grant period.

Signature of Governing Board Chairperson*

Date

* If signed by anyone other than board chairperson, please attach a resolution of the applicant
organization's board authorizing the signatory.

SECTION IV - COMMUNITY NEEDS AND RESOURCES

NAME OF APPLICANT ORGANIZATION

1. State the approximate number of homeless persons in your community/service area.

Source(s):

2. Describe the homeless population that you serve and any changes in this population which you have noticed over the past two years (e.g., increase in special populations such as the elderly, female heads of households, working families not able to afford housing in your market, any decrease in overall homeless population, etc.).
3. Based on your organization's experience, what are the unmet needs of homeless people in your service area?

(Please refer to *Appendix C – Continuums of Care in North Carolina* – to answer the following questions, if necessary.)

4. Does your organization operate in the service area of a recognized Continuum of Care listed in Appendix C?

Yes _____ No _____

If Yes, please enter the name of the Continuum of Care that covers the area (county, city, etc.) in which the facility for which funding is sought is located.

Has your organization been an active and involved member of the Continuum of Care entered above in the last year? (That is, have representatives of your organization attended CoC meeting regularly and/or participated in the development of any CoC applications for funding?)

Yes _____ No _____

If Yes, please list the name(s) and title(s) of your organization's representative(s) at Continuum of Care meetings?

Name _____	Title _____
Name _____	Title _____

If No, why did your organization not participate in your area's Continuum of Care?

___ Did not know that the Continuum of Care group existed.

___ The Continuum of Care has not been active in the last year.

___ We saw no benefit in our organization being a part of the Continuum of Care.

___ Other, Please explain.

5. Identify the major agencies/organizations (overnight shelters, domestic violence shelters, day shelters, soup kitchens, etc.) in your service area that provide services to the homeless.

- a. **Agency Name:**
 Agency Address:

Brief Description of Basic Operation and Services Provided

- b. **Agency Name:**
 Agency Address:

Brief Description of Basic Operation and Services Provided

- c. **Agency Name:**
 Agency Address:

Brief Description of Basic Operation and Services Provided

- d. **Agency Name:**
 Agency Address:

Brief Description of Basic Operation and Services Provided

- e. **Agency Name:**
 Agency Address:

Brief Description of Basic Operation and Services Provided

Please add additional sheets if necessary

SECTION V – SERVICE PLAN

1. Name of Applicant Organization: _____
2. Name of Shelter: _____
3. **Total** Number of Unduplicated Persons to Benefit during the Grant Period: _____

4. **OBJECTIVES:** Indicate the total number of persons expected to benefit during the grant period in each of the categories below utilizing ESGP funds. Enter the number of people to be served **each quarter** in the Implementation Schedule to the right.

IMPLEMENTATION SCHEDULE

Qtr. 1 7/06-9/06	Qtr. 2 10/06 -12/06	Qtr. 3 1/07-3/07	Qtr. 4 4/07 -6/07

- A. Overnight accommodations or day services will be provided to _____ homeless families/individuals during the grant period.

Total ESGP Funds Requested for Operations \$_____

- B. Identify the essential services which will be provided (indicate the number of people expected to be served)
 - a. Assistance in obtaining permanent housing _____
 - b. Medical and psychological counseling and supervision _____
 - c. Employment Counseling _____
 - d. Nutritional Counseling _____
 - e. Substance abuse counseling _____
 - f. Information and referral for obtaining other federal, state and local assistance _____

Total ESGP Funds Requested for Services \$_____

- C. Homeless Prevention services will be provided to _____ homeless families or individuals.

Identify Homeless Prevention activities to be provided:

- | | |
|---|--|
| ___ a. Short-term subsidies to prevent utility shut-off or evictions
___ b. Security deposits
___ d. Mortgage/Rent payments to prevent eviction | ___ e. Mediation services for landlord/tenant disputes
___ c. First
___ f. Legal services for eviction proceedings |
|---|--|

Attach description of services to be provided persons receiving homeless prevention funds. See page X, Section V, Item 5

Total ESGP Funds Requested for Prevention \$_____

SECTION VI
GRANTEE BUDGET INFORMATION
OEO FORM 225

(See Pages xii - xiii of application introduction for instructions)

SECTION VII – SOURCE OF MATCHING FUNDS

Please indicate below the source(s) and amount of funds to be used to match the ESG funds received by your organization. The amount should be at minimum equal to the amount of funds allocated. ***These funds must be provided after the start date of the grant award and may not be used to match another grant during the same period.***

Additionally, following this sheet, **please attach documentation** of the availability of matching funds for the proposed project as described below.

- If funds received from units of local government, churches, foundations, or state government agencies will be used to match ESG funds, attach copies of funding award and/or commitment letters from these sources on their official letterhead and signed by their authorized official.
- If the value of donated volunteer hours will be used to match ESG funds, the applicant organization should provide a letter on its official letterhead signed by its board chairperson describing the records maintained on volunteer hours, indicating the number of volunteer hours donated to the organization during its most recent fiscal year and estimating the number of volunteer hours to be donated during the period of the ESG grant period.
- If the value of a donated building or any lease will be used to match ESG funds, provide documentation of the fair market value of the building or lease.
- If staff salaries are used to match ESG funds, the source of the funds for these salaries should be identified by the applicant organization in a letter on its official letterhead and signed by its board chairperson.

<u>Source of Matching Funds</u>	<u>Amount</u>
_____	\$ _____
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	\$ _____

SECTION VIII – INVENTORY OF ADDITIONAL FUNDING

Your Agency Fiscal Year begins on _____ and ends on _____.

Will the facility for which funding is sought receive funding from other State or Federal funding sources during the period of July 1, 2006 – June 30, 2007? ____ Yes ____ No

If **YES**, please provide the following information (Do NOT include any anticipated ESG Funding):

Name of State/Federal Agency and Program Providing Funding	<u>Funding Amount</u>	<u>Period of Funding</u>
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TOTAL STATE AND FEDERAL FUNDING EXPECTED: _____

Please indicate what other sources are expected to provide funding to the facility for which funding is sought during the period of July 1, 2006 – June 30, 2007 along with the estimated cash funding to be received.

	<u>Expected Funding</u>
_____ Private Foundations	\$ _____
_____ United Way	\$ _____
_____ Church Donations	\$ _____
_____ Donations (Individual and/or Business)	\$ _____
_____ Organization Owned/Operated Enterprises	\$ _____
_____ Fundraising Events	\$ _____
_____ City Funding	\$ _____
_____ County Funding	\$ _____
_____ Client Rent/Boarding Fees	\$ _____
_____ Client Program Service Fees	\$ _____
TOTAL	\$ _____

SECTION IX – SUPPORTING DOCUMENTATION

ATTACH THE FOLLOWING DOCUMENTS:

- A copy of any application or intake form used to admit and/or serve a client served by the homeless facility for which funding is sought.
- A list of staff with position titles for the homeless facility for which funding is sought.
- Applicant organizations that received ESG funding in FY 2005 (July 1, 2005 – June 30, 2006) **MUST** attach a copy of the form they used to verify the homelessness of clients served during **FY 2005**. If a different form will be used in **FY 2006** (July 1, 2006 – June 30, 2007), the applicant organization should also attach a copy of that form. If two forms are included in the application package, applicant organizations should label each form with the respective program year.
- Applicant organizations that did not receive ESG funding in FY 2005 and have been approved to apply for funding in FY 2006 **MUST** attach a copy of the form they will use to verify the homelessness of clients they will serve in FY 2006 (July 1, 2006 – June 30, 2007). If the verification of homelessness form included in Appendix B of this application package will be used by the applicant organization during the FY 2006 program year, a copy of the form should be attached to the application. If the form in Appendix B is not selected for use by the applicant organization, the applicant organization should attach a copy of the verification of homelessness form they intend to use during the FY 2006 program year. **Any form designed by the applicant organization must be approved by OEO prior to use.**

<p style="text-align: center;">APPENDIX A:</p> <p style="text-align: center;">HOMELESS ELIGIBILITY CERTIFICATION GUIDE</p>
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This document provides a description of the documentation grantees are required to maintain on file to verify the homelessness of their clients.

Please keep this guide for reference throughout the program year.

For more information contact:

Libby G. Stanley
SNAPS Coordinator
U.S. Department of Housing and Urban Development
Asheville Building, 1500 Pinecroft Road, Suite 500
Greensboro, North Carolina 27407
Telephone: (336) 547-4000 Ext. 2051 FAX: (336) 547-4148
OR
Homeless Programs Coordinator
Office of Economic Opportunity
2013 Mail Service Center
Raleigh, North Carolina 27699-2013
Telephone: 919-715-5850
Fax: 919-715-6437

HOMELESS/CHRONIC HOMELESS ELIGIBILITY CERTIFICATION GUIDE

In accordance with the McKinney –Vento Act, the following situations (listed below) constitute a homeless situation. They are the most typical types of homeless situations. If there are other situations that are not described here, contact the HUD Field Office for clarification.

Each claim of homelessness must be supported with appropriate documentation. The situations listed below have a number in parentheses which references on pages 2 and 3 the specific documentation required to be in the file.

Also included at the end of this Guide is the definition of a **chronically homeless person**. Only individuals are considered chronically homeless for the COC programs. HUD does not recognize families as being chronic homeless.

It is imperative that you have the proper supporting documentation to demonstrate that a person or family is **homeless** or that an individual is **chronically homeless**.

A person is considered homeless only when he/she resides in one of the places described below:

- **In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street). (1 or 2)**
- **In an emergency shelter. (3)**
- **In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters (make sure you have evidence that the person came from the streets or emergency shelter situation). (4)**
- **In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution. (5)**
- **Is being evicted within a week (7 days) from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. (6)**
- **Is being discharged within a week (7 days) from an institution, such as a mental health or substance abuse treatment facility in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. (7)**
- **Is being released from prison/jail with no subsequent residence identified and the person lacks the resources and support networks needed to obtain housing. (8)**

- Is fleeing a domestic violence-housing situation, no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. (9)
- Is living in substandard housing that has been condemned. (10)

Please use the checklist below to make sure that the type of supporting documentation is maintained in the participant's or other appropriate file:

1 (Places Not Meant for Human Habitation) Certification form signed by the outreach worker or service worker verifying that the person or family is homeless. This could include a letter or certification form signed by an outreach worker or service worker from another organization that can verify that the person or family was, in fact, homeless as described in the above definition, or

2 written statement prepared by the participant about the participant's previous living place (if unable to verify by outreach worker or service worker). Have the participant sign and date.

3 (Shelter) Referral agency certification that the participant has been residing on the street or at the emergency shelter (on agency letterhead, signed and dated).

4 Transitional housing certification (on agency letterhead, signed and dated) if the participant is residing at the transitional housing facility as well as written verification that the participant was living on the streets or an emergency shelter prior to living in the transitional housing facility (see above for required documentation).

5 Short-term institution (up to 30 consecutive days) certification from institution's staff verifying that the participant has been residing in the institution for 30 days or less. There should also be written verification that the participant was residing on the street or in an emergency shelter prior to the short-term stay in the institution.

6 Private dwelling eviction statement describing the reason for eviction (signed and dated by person evicting). No formal eviction is required. If unable to obtain an eviction statement, you must obtain a written statement signed and dated by the participant describing the situation. Outreach worker or service worker must document their efforts by providing a verification form documenting that they have made every effort to confirm that the circumstances are true and have written verification describing the efforts and attesting to their validity. The verification form should be signed and dated. You must also have information on the income of the participant to verify that they lack the financial resources and support networks needed to obtain housing.

7 Institution discharge (over 30 days) certification completed by institution staff stating that the participant was being discharged within the week before receiving SHP

assistance. You must also have information on the income of the participant to verify that they lack the financial resources and support networks needed to obtain housing and that without the SHP assistance, the participant would be living on the street or in an emergency shelter.

__8__ Prison/jail release certification by staff stating that the person was released from prison with no residence identified and that the person lacks the resources and support networks needed to obtain housing.

__9__ Domestic violence statement from the participant that he/she is fleeing a domestic violence situation. If participant is unable to prepare a written statement, staff should prepare the statement about the participant's previous living situation and have the participant sign and date it. You must document that you have verified the income of the participant and certify that they lack the financial resources and support networks needed to obtain housing and that without the SHP assistance, the participant would be living on the street or in an emergency shelter.

__10__ Substandard housing that has been condemned requires an official condemnation notice.

Each homeless person's file should contain the required evidence of homelessness listed in 1-10 above.

NOTE: ANSWERING "YES" TO A QUESTION ON AN APPLICATION ASKING IF A PERSON IS HOMELESS IS NOT SUFFICIENT EVIDENCE OF HOMELESSNESS.

CHRONICALLY HOMELESS PERSON: An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least 4 episodes of homelessness in the past three (3) years. To be considered chronically homeless a person must have been on the streets or in an emergency shelter (i.e., not transitional housing) during these stays.

NOTE: You will be expected to prove that the chronically homeless person has been "continuously" homeless for a year or more OR that the person has had the 4 episodes of homelessness in the past three (3) years. This documentation could be a certification (on letterhead) from an emergency shelter certifying that the person has been staying in a camp, street, car and sometimes in the emergency shelter for the last year as documented by outreach efforts or been a resident in their shelter at least 4 times during the past 3 years.

Also, you should have documentation related to the client's disability. While we understand that you might not have or be able to get a Doctor's diagnosis of disability, you must have some narrative documentation related to the disabling condition that most likely results in their chronic homelessness.

APPENDIX B

SAMPLE

VERIFICATION OF HOMELESSNESS FORM

The following form was prepared by the Office of Economic Opportunity (OEO) to provide ESG grantees with a sample of an appropriate form which can be used to certify the homelessness of clients served in the applicant's homeless facilities. The use of this particular form is not mandatory; however, the grantee should design a form to use for this purpose. A form designed by the grantee to verify client homelessness must be approved by OEO. **This form and any OEO approved form designed by the grantee should be used in conjunction with the Homeless Eligibility Certification Guide included as Appendix A of this application.**

(Name of organization here)

Verification of Homelessness

NOTE TO STAFF: See Homeless Eligibility Certification Guide for detailed explanation of documentation which must be attached to this form.

Program Applicant Name: _____

Interviewed by Program Staff Member: _____

Referred By: _____

Date of Interview: _____

1. As of today, do you have some place in this area that you consider to be a permanent place where you live? A permanent place would be a house that you rent or own, an apartment that you rent, a room (other than a hotel room) that you rent, or a living arrangement with a relative or a friend to sleep in their place on a regular basis (5 or more days a week)?

☐ Yes (STOP HERE) ☐ No (If No, Continue)

Program Staff: An individual who is living in substandard housing that has been condemned as unfit for human habitation could be considered homeless under HUD's definition of homelessness although not stated in specific program regulations.

2. If you do not have a permanent residence, where have you been living for the last 7 days?

☐ Homeless Shelter

Shelter Name and Location: _____

☐ Transitional Housing Facility (designed for homeless persons)

Facility Name and Location: _____

- ☐ In a car, van, truck, or other vehicle
☐ Anywhere outside (on the streets, in parks, in campgrounds)
☐ In a migrant worker camp
☐ In an Abandoned Building
☐ Other (Specify: _____)

Program Staff: Letter of verification from director of homeless shelter or transitional housing facility must be attached to this form if one of the first two options above is checked. If other options are checked, document in writing the indicated living situation with law enforcement reports/referrals, social service agency referral, staff verification, etc. and attach.

3. Have you recently been evicted from a house that you rented or owned, an apartment you rented, or a room (other than a hotel room) you rented?

☐ Yes ☐ No

Program Staff: Attach copy of eviction notice or letter from landlord indicating his intent to begin eviction proceedings.

4. Were you recently asked or forced to leave a living situation by a family member or friend?

☐ Yes ☐ No

If Yes, why were you asked/forced to leave? (Check all that apply)

- ☐ Overcrowded ☐ Family Dispute
☐ Substance Abuse ☐ Failure to contribute to household income
☐ Domestic Violence ☐ Other (Specify): _____

Program Staff: If domestic violence is indicated attach statement signed by client attesting that he/she is fleeing domestic violence. If other options are checked, attach statement from family member or friend attesting to client situation. If not possible to obtain such a statement, attach documentation of staff efforts to secure such a statement.

5. What is your current income? _____ per _____
Do you feel you have the financial means to obtain and maintain a permanent place to stay?
☐ Yes ☐ No

I, _____, do hereby certify that the answers I
(Printed Name of Program Applicant)
have given to the preceding questions are true and accurate.

(Signature of Program Applicant)

(Date)

Persons served by this facility should be homeless according to the following definition used by the Emergency Shelter Grants (ESG) Program.

*A person is **homeless** if he/she is "an individual who lacks a fixed, regular and adequate nighttime residence, or an individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and/or transitional housing for the mentally ill); (b) a public or private place that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human beings."*

Based on the responses to the preceding questions given by the above program applicant,

I, _____, a staff member of _____,
(Printed Staff Member Name) (Organization/Facility Name)

find that, _____, ☐ is ☐ is not homeless according to
(Name of Program Applicant)

the definition of homelessness stated above.

(Signature of Staff Member)

(Date)

This completed form, along with all necessary attachments, must be filed in the program applicant's file if he/she is accepted into the program.

APPENDIX C

CONTINUUMS OF CARE IN NORTH CAROLINA
(AS OF MARCH 15, 2004)

North Carolina Continuums of Care

PRIMARY AREAS

Bladen, Columbus, Hoke
Robeson and Scotland Counties

Buncombe County/Asheville

Ashe, Avery, Allegheny, Mitchell,
Watauga, Wilkes and Yancey Counties

Hickory and Catawba County

Carteret, Craven, Jones, & Pamlico Counties

Anson, Montgomery, Moore &
Richmond Counties

COC/CONTACT

Gail McCrae
Four County Community Services
P.O. Box 988
Laurinburg, NC 28353
(910) 277-3523
mcraegm@carolina.net

Robin Merrell
Pisgah Legal Services
P.O. Box 2276
Asheville, NC 28802
(828) 253-0406
robin@pisgahlegal.org

Jennifer Herman
Oasis, Inc.
P.O. Box 1591
Boone, NC 28607
(828) 264-1532
director@oasisinc.org

Rev. Tom Sanford
Family Care Center of Catawba
1471 1st Avenue
Hickory, NC 28602
(828) 324-9917
familycare@twave.net

Kathy Moran
Neuse Ctr. Area MH/DD/SAS
P.O. Box 1636
New Bern, NC 28563
(252) 638-7900
kmoran@neusecenter.org

Nezzie Smith
Sandhills Community Action
Program
103 Saunders Street
Carthage, NC 28327-0937
(910) 947-5675
nezziesmith@earthlink.net

**Alamance, Rockingham, Caswell Counties
& Burlington**

Susan B. Taylor
City of Burlington
P.O. Box 1358
Burlington, NC 27216-1358
(336) 222-5094
staylor@ci.burlington.nc.us

**Davidson, Cabarrus, Rowan, Union & Stanley
Counties**

James Curtin
Piedmont Behavioral Health
245 LePhillip Court NE
Concord, NC 28025
(704) 721-7066
jamescu@pamh.com

Durham County & Durham

Tyrone Lindsey
Durham Affordable Housing
Coalition
331 W. Main Street, Suite 408
Durham, NC 27701
(919) 683-1184
tyrone@dahc.org OR
Rich Lee
(919) 683-1185
rich@dahc.org

Fayetteville & Cumberland County

Thanena Wilson
Cumberland County
245 Person Street
Fayetteville, NC 28302
(910) 323-6112
tswilson@co.cumberland.nc.us

**Gaston, Lincoln, Cleveland Counties
& Gastonia**

Angela Williamson
City of Gastonia
Community Development
P.O. Box 1748
Gastonia, NC 28053-1748
(704) 867-0756
angeladwmson@bellsouth.net
and
Mary McCreight
Reinvestment in Communities
181 S. South Street
Gastonia, NC 28053-1748
(704) 866-6753
Maryconsulting@aol.com

Greensboro, High Point & Guilford Counties

Jackie Butler
ADS
5209 Wendover Avenue
High Point, NC 27265
(336) 812-8652
jbutler@adsyes.org

Greenville & Pitt County

Margaret Dixon
P.O. Box 687
Greenville, NC 27835-0378
(252) 902-1068
mmdixon@co.pitt.nc.us

**Goldsboro & Wayne, Sampson, Lenoir, Duplin
& Counties**

Judy Pelt, Director
Wayne County DSS
301 N. Herman Street
Box HH
Goldsboro, NC 27530
(919) 731-1074
judy.pelt@ncmail.net

Jacksonville & Onslow County

Patricia Hatch
City of Jacksonville
P.O. Box 128
Jacksonville, NC 28541
(910) 938-7758
phatch@ci.jacksonville.nc.us

Mecklenburg County & Charlotte

Paul Walker
Mecklenburg Co. Area Mental Health
429 Billingsley Road
Charlotte, NC 28211
(704) 3360-7758
walkerpm@co.mecklenburg.nc.us

Orange County & Chapel Hill

Billie Guthrie
OPC Area Program
100 Europa Drive, Suite 490
Chapel Hill, NC 27517
(919) 913-4070
bguthrie@opc-mhc.org

Randolph County

Bonita Parker
Randolph Co. MH/DD/SAS
110 W. Walker Avenue
Asheboro, NC 27203
(336) 633-7200
bonita.porter@rcmh310.net

Rocky Mount & Nash and Edgecombe Counties

Chris Battle
United Community Ministries
P.O. Box 2624
Rocky Mount, NC 27802
(252) 985-0078
chrisbattle123@earthlink.net

Salisbury & Rowan County

Janet Gapen
City of Salisbury
P. O. Box 479
Salisbury, NC 28145-0479
(704) 638-5230
jgape@salisburync.gov

Iredell & Yadkin Counties

Jackie Copeland
Crossroads Behavioral Health Care
200 Business Park Drive
Elkin, NC 28261
(336) 835-1000
JCopeland@crossroadsbhc.org

Surry County

Jane Motsinger
The Ark Shelter
P.O. Box 102
Elkin, NC 28621
(336) 366-2922
jmotsinger@surry.net

Wake County & Raleigh

David Harris, Co-Chair
Wake County Human Services
P.O. Box 46883
Raleigh, NC 27610-6833
(919) 212-7723
kferguson@co.wake.nc.us

OR

Jeanne Tedrow, Co-Chair
Passage Home
P.O. Box 17558
Raleigh, NC 27619
(919) 834-0666 Ext. 230
Jmct77@aol.com

**Wilmington & New Hanover, Pender, &
Brunswick Counties**

Rebecca Dixon
VOA of the Carolinas
108 N. Kerr Avenue, Suite C-3
Wilmington, NC 28405
(910) 793-2850
voadths@aol.com

Winston-Salem & Forsyth County

Monica Lett
City of Winston-Salem
P.O. Box 2511
Winston-Salem, NC 27102
(336) 727-8597
monical@cityofws.org

Franklin, Granville, Vance & Warren Counties

Joel Rice
VGFW Area Authority
134 S. Garnett Street
Henderson, NC 27536
(252) 430-1330
jrice@vgfw.ncmh.org

Johnston, Lee & Harnett Counties

Marie Watson
JLH Community Action
P.O. Drawer 711
Smithfield, NC 27577
(919) 934-2145
jlhca@earthlink.net

**Martin, Washington, Tyrell, Beaufort &
Hyde Counties**

Amy Modlin
Tideland Mental Health Center
1308 Highland Drive
Washington, NC 27889
(252) 975-4695 Ext. 2256
amodlin@tideland.org

**Haywood, Jackson, Swain, Graham, Macon, Clay
& Cherokee Counties**

Kristi Case
Smoky Mountain Center
P.O. Box 127
Sylva, NC 28799
828-586-5501 Ext. 1202
casekristi@smokymountaincenter.com